STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
		155770	B. WING		06/03/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L.				
\/II I A S (OF GUERIN WOOD	ie.	l l	ISTER BARBARA WAY GETOWN, IN47122		
VILLAG	OF GUERIN WOOD	3	GEORG	3E10VVIN, IN47122		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
	This visit was for	r Investigation of	F0000	Submission of this plan		
	Complaint IN000	090126.		ofcorrection shall not constitu		
	1			admission by The Villas of G	•	
	Complaint INO00	090126 - Substantiated.		Woods to the allegation cont in this survey report. The Vi		
	•			Guerin Woods specifically ar	•	
		ficiencies related to the		generally denies that the sur		
		ited at F223, F225, and		allegations are indicative of t	· 1	
	F226.			quality of nursing care and		
				serviceprovided to the reside	ents	
	Survey dates: 6/2	2 and 6/3/11		ofthis health care facility. Thi	S	
				plan of correction issubmitted	d in	
	Facility number:	011500		accordance withthe requirem	•	
	_			of the Stateand Federal law.		
	Provider number					
	AIM number: 20	00909280				
	Survey team: Jei	nnie Bartelt, RN				
	-					
	Census bed type:					
	SNF: 15	•				
	SNF/NF: 14					
	Total: 39					
	Census payor typ	pe:				
	Medicare: 1					
	Medicaid: 10					
	Other: 28					
	Total: 39					
	10181. 39					
	Sample: 4					
	These deficiencie	es also reflect state				
	findings cited in	accordance with 410 IAC				
	16.2.					
	10.4.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4RJO11

Facility ID:

011509

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155770		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER		•	1002 SI	DDRESS, CITY, STATE, ZIP CODE STER BARBARA WAY SETOWN, IN47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0223 SS=D	The resident has t verbal, sexual, phy corporal punishme seclusion.	/11 by Suzanne Williams, RN he right to be free from ysical, and mental abuse, ent, and involuntary ot use verbal, mental,					
	punishment, or inv Based on reco interview, the ensure residen mental and ver residents revie	roluntary seclusion. rd review and facility failed to ts were free from rbal abuse for 3 of 4 wed related to abuse in a sample of B, D, and E)	F0	223	F223 Resident B- was interviewedby the Quality of Director on May 27, 2011, to determine if there had been so other instances of perceived abuse or neglect by care given No instances were identified. This Resident has notexperienced a weight loss and attends activities as prior this incident. (Exhibit #1). Resident D-was interviewed the Quality of Life Director on 29, 2011 to determine if there	any ers s to by April	07/03/2011
	6/2/11 at 2:40 Administrator had reported for abuse to the In Department of Assistant Admitwo nurses and "let go" very reproblems, and	Health recently. The inistrator indicated done aide had been ecently related to the a third nurse had ed at an earlier time.			been any other instances of perceived abuse or neglect by care givers. No instances we identified. This resident has no experienced a weight loss and attends activities as prior to the incident (Exhibit #2). Residen was interviewed by the Quality Life Director on April 29, 2011 determine if there had been an other instances of perceived abuseor neglect by care giver No instances were identified. This resident has not experienced a significant weig loss and attends activities as prior to this incident (Exhibit 3) residents were interviewed by		

l i '			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155770	A. BUI	LDING	00	COMPLETED 06/03/2011	
		199770	B. WIN	_		00/03/2011	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
\/II I A C (OF GUERIN WOOD	e			STER BARBARA WAY SETOWN, IN47122		
				L	3E I OVVIN, IIN47 122		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE	
1710		staff need to realize	1	1/10	Quality of Life Director, starti		
		bad day" is not an			April 29, 2011 and completed	don	
	excuse for what	·			May 27, 2011. These questionswere related to all f	orms	
		se of a resident. The			of abuseand neglect. No	oiiiio	
					instances ofperceived abuse		
		inistrator indicated			neglect wereidentified (Exhib 4). Staff members Certified N		
	one of the abu				Aid#2, Licensed Practical Nu		
	happened whe	n a CNA turned a			#3, and Licensed Practical N		
	resident into a	bed rail, but the			#5, were respectfully termina 5/2/11,5/21/11, 5/31/11. The		
	resident was ca	aught by another aide			Board ofNursing was notified		
	so injury did not occur.				telephone onMay 2, 2011 an		
					May 31, 2011related to findir	- 1	
	 The facility's r	oolicy entitled "Abuse			by Directorof Nursing and Hu Resources.Attorney General		
	_	licy" was provided by			which was notified on June 1		
		ator on 6/2/11 at 4:40			2011 (Exhibit #5). The Administrator and The Direct	or of	
					Nursing reviewed the Abuse		
	p.m. Review of				Neglect Policy and Procedur		
		nitions including, but			April 29, 2011 (Exhibit #6).		
	not limited to,	"Abuse: Mental -			Director of Nursing in-service the staff on the Abuse and	ea	
	Includes, but is	s not limited to,			Neglect Policy and Procedur	e	
	humiliation, ha	arassment, threats of			including the requirements to		
	punishment, or	r spiritual and			report any suspected abuse neglect immediately on April		
	·	vell-beingAbuse:			2011 and completed on April	· •	
		s to any use of oral,			2011. This in-service was		
		tured language that			followed with a written post to ensure competence in the	est to	
	includes dispar				knowledgeof abuse and negl	ect	
	_				(Exhibit#7). The Director of		
		ms to Elders or their			Nursing will in-servicestaff quarterly for one year,		
		thin their hearing			thenannually thereafter		
		scribe Elders in a			ongoing(Exhibit #8). The Pol		
	negative mann	er, regardless of their			educating all new employees to working at the Villas will	prior	
	age, ability to	comprehend, or			continue. Effective 6/5/11,all		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155770 06/03/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN47122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE applicants during the disability. Use of vulgar language interviewprocess will be given a within the hearing distance of behavior test to ascertain any Elders...." potential of abusive or harsh behavior and willbe dismissed from the interview process Upon request, files related to accordingly (Exhibit #9). Any temporary staff being utilized has allegations of abuse received by the been and will be in-serviced on facility were placed on the work the SPECIFIC facilities Abuse and NeglectPolicy and Procedure table in Villa 2 and found on 6/2/11 of the Villas(Exhibit #10). The at 5:55 p.m. Review of the files Quality of Life Director in-servicethe Resident Council on indicated the following related to abuse and neglect on May 27, care of Residents B, D, and E. 2011 and March 21, 2011. The elders wereinstructed to tell any staff theyfelt comfortable 1. Review of the file related to speaking to if there were Resident E, indicated in "Brief concerns and/or to ask to speak with the Director of Nursing or Description: The Director of Administrator (Exhibit # 11). The Nursing was approached on Quality of Life Director will audit. through interview 15% of 4/27/2011 at 1:00 p.m. by [name], theelders randomly to identify any Certified Nursing Aide [CNA #4], perceived instances of Abuse and Neglect weekly for 4 weeks. stating she wanted to meet with biweeklyfor two months, monthly her....There was an allegation made for three months, then as of physical abuse related to recommended by the Quality Assurance Committee. These transferring an Elder...." The Audits will be presented to document indicated the alleged theAdministrator on an going basis(Exhibit #12). The perpetrator, CNA #2, was placed Administrator will bring on suspension 4/27/11, pending theseaudits to the Quality Assurance Committee for any investigation, and terminated on recommendationsfor further 5/2/11. actions. A handwritten statement, signed by

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B. WING	
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY	
VILLAS OF GUERIN WOODS GEORGETOWN, IN47122	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFLY (EACH DEFICIENCY MUST BE DEPICEDED BY FULL PREFLY (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
CNA #4 on 4/29/11, indicated, "On	
4/25/11, [name of CNA #2] and I	
were getting [name of Resident E]	
up and dressed for the day. When	
changing her nightshirt [name of	
CNA #2] was very rough and	
pulling on her arms. When rolling	
her over she did not wait for	
assistance from me or give Elder	
any warning what she was doing. I	
had pulled the bed away from the	
wall to be able to assist on the	
opposite side and caught [name of	
Resident E] before her head hit the	
railing. The rest of the day when	
[name of CNA #2] would approach	
[name of Resident E] would close	
her eyes and pretend to be asleep.	
[Name of CNA #2] did try to feed	
[name of Resident E] at breakfast	
but was loud and acting in a very	
forceful manner and [name of	
Resident E] would not open her	
eyes or mouth"	
2. Review of the file related to	
Resident D, indicated in "Brief	
Description: The Director of	
Nursing was approached on	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUI COMPLET		
		155770	B. WIN			06/03/201	1
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE STER BARBARA WAY		
VILLAS (OF GUERIN WOOD	S		GEORG	GETOWN, IN47122		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION DATE
	4/27/2011 at 1	:00 p.m. by [name],					
	Certified Nurs	ing Aide [CNA #4],					
	stating she was	nted to meet with					
	herThere wa	as an allegation made					
	of mental abus	se related to a					
	comment mad	e about odor during					
	elimination."						
		lleged perpetrator,					
		placed on suspension					
	4/27/11, pending investigation, and						
	terminated on 5/2/11.						
	A handwritten	statement, signed on					
		ated, "On 4/25/11					
	•	dent D] had an					
	-	of bowel issue. She					
	was very upset	t with herself that she					
	• •	lp in cleaning up. I					
		that it was no big					
		of CNA #6] and I					
	cleaned her up	(shower) and got her					
	settled in the li	iving room after					
	assuring her th	at no one but us					
	knew what wa	s going on. [Name of					
	LPN #3] then	walked in and said,					
		t is that smell?' all					
		ame of Resident D].					
	I came into the	e nurses station and					
	whispered that	[name of Resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155770		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE STER BARBARA WAY SETOWN, IN47122	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	D] had a bowe not gotten ever yet I went to he the bathroom a [name of LPN [name of Resident D's] is spraying air from and all a Resident D] we of the living room and all a Resident D] we and was afraid what had happed 3. Review of the Resident B incompact of the living room and all a greater than the living room and all a resident D] we and was afraid what had happed 3. Review of the Resident B incompact of the living room and all a greater than the living room and all a resident D] we and was afraid what had happed 3. Review of the Resident B incompact of the living room and all a greater than	l problem and I had rything cleaned up elp another Elder to and when I came back #3] had walked into dent D's] room and ler! Nothing has ap! [Name of LPN into [name of room and bathroom eshener and ying outside of the round [name of ho was sitting in one bom chairs. [Name of as crying at this point that everyone knew		I	CROSS-REFERENCED TO THE APPROPRIA	TE	
	_	reporting any abuse trator and Director of DON was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155770		BUILDING WING	00	COMPLETED 06/03/2011
NAME OF PROVIDER OR SUPPLIER VILLAS OF GUERIN WOODS	•	1002 SI	DDRESS, CITY, STATE, ZIP CODE STER BARBARA WAY SETOWN, IN47122	
(X4) ID SUMMARY STATEMENT (PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTII	PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
approached by [name] Nurse Aide [CNA #6], she had an abuse alleg a nurse. [Name of CN that the nurse was [nar #5], Licensed Practical was being verbally abuselder. She stated that [LPN #5] would tell eld up, knock it off and quas a baby." The documenthe alleged perpetrator was suspended 5/25/11 investigation, and term 5/31/11. A handwritten statemet and dated 5/26/11, by sindicated related to vert Resident B, "[Name of went in to [name of Reference of Resident B, yelled her to shut up, knock it acting like a baby. I to leave and I would do it statement did not indicated of the verbal abuse. A handwritten statemet	stating that ation against [A #6] stated me of LPN I Nurse, who usive to this [name of der to 'shut hit acting like nt indicated [, LPN #5, I, pending hinated on mt, signed CNA #6 rbal abuse of [LPN #5] esident B] at her told tt off, and quit old her to t" The eate the date			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155770			ĺ	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE STER BARBARA WAY ETOWN, IN47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	and dated 5/27 indicated, "I had a class abde control of the control of times. As in some series are the control of times are the control of times. As in some series are the control of times are the control of times.	2/11, by CNA #10 ave witnessed [name ing verbally rough Resident B] a few aying '[Name of ou need to stop your needed and ridiculous' torked together. Also er voicing her the elders from the a the kitchen." ew on 6/3/11 at 12:15 reporting allegations a #10 indicated he had out abuse, and "now I ey're looking for."			CROSS-REFERENCED TO THE APPROPRIA	TE	
	3.1-27(a)(1) 3.1-27(b)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155770			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/03/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE STER BARBARA WAY GETOWN, IN47122	l
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	The facility must in have been found gor mistreating resishave had a finding nurse aide registry mistreatment of reof their property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including ir and misappropriat reported immediate the facility and to with State law through (including to the Sagency). The facility must halleged violations and must prevent the investigation is the investigation is state survey and covering days of the violation is verified action must be tak Based on reconstants.	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an avould indicate unfitness for a aide or other facility staff to de registry or licensing on the registry or licensing on the administrator of other officials in accordance ough established procedures tate survey and certification ave evidence that all alleged further potential abuse while in progress. Investigations must be ministrator or his designated in to other officials in the alleged appropriate corrective incident, and if the alleged appropriate corrective and review and review and review and review and review and review and	F0225	F 225	07/03/2011
	· ·	facility failed to ported allegations of ately to the		Residentf Bwas intferviewed by tfhe Qualitfy oft Lifte Directfor May 27, 2011, tfo detfermine ift t	

l ·		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155770	B. WIN			06/03/2	011
NAME OF	PROVIDER OR SUPPLIEF	,		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	FROVIDER OR SUFFLIER			1002 SI	STER BARBARA WAY		
VILLAS	OF GUERIN WOOD	OS .		GEORG	GETOWN, IN47122		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	Administrator	for 3 of 4 residents			had been any otfher instfances of	t	
	reviewed relat	ed to allegations of			perceived abuse or neglectf by caregivers. No instfances were		
	abuse in a sam	pple of 4. (Residents			identffted. This residentf has notf		
	B, D, and E)	1			experienced a weightf loss and		
	[D, D, and D]				atfends actfvitfes as prior tfo tfhis		
					incidentf(Exhibitf #1).		
	Findings inclu	ide:					
					Residentf D was intferviewed by the	fhe	
	Upon request, files related to allegations of abuse received by the				Qualitfy oft Lifte Directfor on April 29, 2011 tfo detfermine ift tf	horo	
					had been any otfher instfances of		
	1				perceived abuse or neglectf by car		
	facility were placed on the work				givers. No instfances were identff		
		cility's Villa 2 and			This residentf has notf experience	d	
	found on $6/2/1$	11 at 5:55 p.m.			a weightf loss and atfends actfvitfo	es	
	Review of the	files indicated the			as prior tfo tfhis inciden (£xhibitf #	2).	
	following rela	ted to care of			Residentf E was intferviewed		
	Residents B, I				by the Quality oft Lifte Directfor		
	Residents D, I	o, and E.			on April 29, 2011, tfo detfermine		
					ift tfhere had been any otfher		
		the file related to			instfances oft perceived abuse or		
	Resident E, in	dicated in "Brief			neglectf by care givers		
	Description:	The Director of			No instfances were identffted This residentf has notf experienced a	5	
	Nursing was a				signiftcantf weightf loss and atfen	ds	
	1	:00 p.m. by [name],			actfvitfes as prior tfo tfhis incident		
					(Exhibitf #3).		
		sing Aide [CNA #4],					
		nted to meet with			All residentfs were intferviewed b		
	herThere w	as an allegation made			The Qualitfy oft Lifte Directfotfartl	ng	
	of physical ab	use related to			on April 29, 2011 and completfed on		
	transferring ar				May		
		· *** + = • • • •			27, 2011. These questfons were		
	A 1 1	-4-4 11			relatfed		
		statement, signed by			tfo all ftorms oft abuse or neglect	ō	
	CNA #4 on 4/	29/11, indicated, "On			instfances oft perceived abuse or		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155770 06/03/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN47122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE neglectf were identffted Exhibitf #4). 4/25/11, [name of CNA #2] were getting [name of Resident E] up and dressed for the day. When changing her nightshirt [name of Stfaft members Certffted Nurse Aid #2, Licensed Practfcal Nurse #3, and CNA #2] was very rough and Licensed Practfcal Nurse #5, were pulling on her arms. When rolling respectfully tferminatfed or 5/2/11, her over she did not wait for 5/21/11, 5/31/11. The Board oft Nursing was notffted by tfelephone assistance from me or give Elder any warning what she was doing. I May 2, 2011 and May 31, 2011 relatfed tfo ftndings by Directfor had pulled the bed away from the oft Nursing and Human Resources wall to be able to assist on the Atforney General which was notffted opposite side and caught [name of on June 17, 2011 (Exhibitf #5). Resident E] before her head hit the The Administfratfor and tfhe Directfor railing. The rest of the day when oft Nursing reviewed thhe Abuse and [name of CNA #2] would approach Neglectf Policy and Procedure on April 29, 2011 (Exhibitf #6). [name of Resident E] would close her eyes and pretend to be asleep. The Directfor oft Nursing inserviced [Name of CNA #2] did try to feed tfhe stfaft on tfhe Abuse and Neglectf Policy and Procedure including tfhe [name of Resident E] at breakfast requirementfs tfo reportf any but was loud and acting in a very suspectfed abuse or neglectf immediatfely forceful manner and [name of on April 28, 2011 and completfed on Resident E] would not open her April 30, 2011. This in-service was eyes or mouth...." ftollowed witfh a writfen postf tfestf tfo ensure competfence in knowledge oft abuse and neglectf (Exhibitf # 7). 2. Review of the file related to Resident D, indicated in "Brief The Directfor oft Nursing will Description: The Director of Nursing was approached on stfaft quartferly ftor one yeathen 4/27/2011 at 1:00 p.m. by [name], annually

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155770 06/03/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN47122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE tfhereafter ongoing(Exhibitf #8). Certified Nursing Aide [CNA #4], stating she wanted to meet with The Policy oft educating all new her....There was an allegation made employees prior tfo working atf tfhe of mental abuse related to a Villas will contfnue. Eftectfvely 6/20/11. comment made about odor during all applicantfs during thhe intferview elimination." process will be given a behavior tfestf tfo ascertfain any potfentfal oft abusive or harsh behavior and will A handwritten statement, signed on 4/29/11, indicated, "On 4/25/11 dismissed ftrom tfhe intferview process [name of Resident D] had an accordingly (Exhibitf #9). incontinence of bowel issue. She was very upset with herself that she Any tfemporary stfaft being utflized had to have help in cleaning up. I has been and will be in-serviced on reassured her that it was no big deal. [Name of CNA #6] and I **SPECIFIC** ftacilitfy Abuse and Neglectf Policy and Procedures oft thhe Villas cleaned her up (shower) and got her (Exhibitf #10). settled in the living room after The Quality oft Lifte Directforservice assuring her that no one but us tfhe Residentf Council on abuse and knew what was going on. [Name of neglectf on May27, 2011 and March LPN #3] then walked in and said, 21, 2011. The Elders were instfructfed 'My god! What is that smell?' all tfell stfaft tfhey fteltf comftortfable right beside [name of Resident D]. speaking tfo I came into the nurses station and ift tfhere were concerns and tr tfo ask tfo speak tfo tfhe Directfor oft Nursing whispered that [name of Resident D] had a bowel problem and I had Administfratfo(Exhibitf #11). not gotten everything cleaned up The Qualitfy oft Lifte Directfor will yet I went to help another Elder to auditf,tfhrough intferview15% oft the bathroom and when I came back tfhe elders randomly tfo identffty any [name of LPN #3] had walked into perceived instfances oft abuse and

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155770	B. WIN		- 	06/03/2	011
NAME OF I	PROVIDER OR SUPPLIEF	.	'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	STER BARBARA WAY		
VILLAS (OF GUERIN WOOD	OS .		GEORG	GETOWN, IN47122		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	~	dent D's] room and			neglectf weekly fto4 weeks, biwee ftor tfwo montfhtfhen as	ekly	
	said, 'No wone	der! Nothing has			recommended		
	been cleaned i	up! [Name of LPN			by tfhe Qualitfy Assurance		
	#3] then went	into [name of			Commitfee.		
	I =	room and bathroom			These auditfs will be presentfed tf		
	spraying air fr				Administfratfor on an ongoing bas	is	
	1 ^ ' '				(Exhibitf #12).		
	continued spraying outside of the room and all around [name of				The Administfratfor will bring tfhe	se	
					auditfs tfo tfhe Qualitfy Assurance		
	Resident D] w	who was sitting in one			Commitfee ftor any		
	of the living room chairs. [Name of				recommendatfons		
	Resident D] was crying at this point				ftor fturtfher actfons		
	I =	that everyone knew			Stfaft ftles were auditfed a 1 00% o	n	
					June 17, 2011 ftor license backgro		
	what had happ	Jeneu			Check by Jennifter Nally HR. All st	faft	
					was ftound tfo have acceptfable		
	During intervi	lew with on $6/2/11$ at			license	·c	
	2:05 p.m., the	Assistant			background check in place (Exhibi #13).	u	
	Administrator	indicated CNA #4			257.		
	was no longer	on staff at the					
	facility. The A						
	1 -	indicated she did not					
	ı	VA #4 waited two days					
	_	oncerns related to the					
	abuse. The As	ssistant Administrator					
	indicated the f	facility had been					
	inservicing fre	equently about abuse					
	prior the repor						
	become more						
		awarc.					
	3. Review of	the file related to					

SUBJECT STATE A BUILDING SUBJECT STATE ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					INSTRUCTION 00	(X3) DATE S COMPL	
VILLAS OF GUERIN WOODS (CA) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEPICENCE MISST BLE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING REFORMATION) Resident B indicated in "Brief Description: At the monthly staff meeting Director of Nursing [DON] was talking to the staff about abuse and different types of abuse. The staff was being instructed on the importance of reporting any abuse to the Administrator and Director of Nursing. The DON was approached by [name], Certified Nurse Aide [CNA #6], stating that she had an abuse allegation against a nurse. [Name of CNA #6] stated that the nurse was [name of LPN #5], Licensed Practical Nurse, who was being verbally abusive to this elder. She stated that [name of LPN #5] would tell elder to 'shut up, knock it off and quit acting like a baby." The document indicated the alleged perpetrator, LPN #5, was suspended 5/25/11, pending investigation, and terminated on 5/31/11. A handwritten statement, signed and dated 5/26/11, by CNA #6			155770	- 1			06/03/20	011
VILLAS OF GUERIN WOODS GEORGETOWN, IN47122 CX51) CX51 C	NAME OF F	PROVIDER OR SUPPLIER		-				
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A handwritten statement, signed and dated 5/26/11, by CNA #6		_						
and dated 5/26/11, by CNA #6								
and dated 5/26/11, by CNA #6		A handwritten	statement, signed					
indicated related to verbal abuse of		indicated relate	ed to verbal abuse of					
Resident B, "[Name of LPN #5]		Resident B, "[]	Name of LPN #5]					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		INSTRUCTION 00	(X3) DATE S COMPL	
		155770	B. WIN			06/03/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VILLAS (VILLAS OF GUERIN WOODS			1	STER BARBARA WAY SETOWN, IN47122		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		1	ID	·	1	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) went in to [name of Resident B]			PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT			COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	-	-					
	-], yelled at her told					
	•	knock it off, and quit					
	_	aby. I told her to ould do it" The					
		not indicate the date					
	of the verbal a						
	or the verbur a	ouse.					
	A handwritten	statement, signed					
		7/11, by CNA #10					
		ave witnessed [name					
	of LPN #5] be	ing verbally rough					
	with [name of	Resident B] a few					
	times. As in s	aying '[Name of					
	Resident B] yo	ou need to stop your					
	yelling it's unn	needed and ridiculous'					
		orked together. Also					
	I have heard he						
	•	the elders from the					
	office while in	the kitchen."					
	Daning interni	(/2/11 -4 12:15					
	_	ew on 6/3/11 at 12:15					
	•	reporting allegations					
	·	x #10 indicated he had out abuse, and "now I					
		ey're looking for."					
	Kilow what the	y io looking loi.					
	During intervi	ew on 6/3/11 at 2:05					
	_	stant Administrator					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4RJO11 Facility ID:

011509

If continuation sheet

Page 16 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION OO			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155770	A. BUILD	ING		06/03/2	
			B. WING	STREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				STER BARBARA WAY		
VILLAS OF GUERIN WOODS				GEORG	ETOWN, IN47122		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	indicated that	· · · · · · · · · · · · · · · · · · ·					
	re-inserviced o	on what abuse is, and					
		g. She indicated one					
	_	s a new employee at					
		d her at the other					
	facility they "c	lidn't consider it					
	abuse like here."						
	This federal tag related to						
	Complaint IN00090126.						
	3.1-28(c)						
F0226 SS=D	written policies and mistreatment, negli and misappropriati	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property.					
	Based on recor	rd review and	F022	26	F226		07/03/2011
	interview, the facility failed to ensure staff followed the facility's policy for reporting allegations of			Residentf B was intf	Residentf B was intferviewed		
					by tfhe Qualitfy oft Lifte Directfor o	here	
					May 27, 2011, tfo detfermine ift tfl had been any otfher instfances oft		
	abuse immedia	· ·			perceived abuse or neglectf by		
		for 3 of 4 residents			care givers. No instfances were identifted. This resident has not		
		ed to allegations of			experienced a weightf loss and		
		ple of 4. (Residents			atfends activities as prior to this		
	B, D, and E)				incidentf(Exhibitf #1).		
	Findings inclu	de:			Residentf Dwas intferviewed by tfr Qualitfy oft Lifte Directfor on April 29, 2011 tfo detfermine ift	ne	
	The facility's p	policy entitled "Abuse			there had been any other instran- oft perceived abuse or neglectf by		

li ´		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
		155770	B. WIN	G		06/03/2011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
				1	STER BARBARA WAY	
VILLAS OF GUERIN WOODS				GEORG	GETOWN, IN47122	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	IAG	care	DATE
		licy" was provided by			givers. No instfances were identff	ted
		ator on 6/2/11 at 4:40			This residentf has notf experience	
	p.m. Review of	of the policy			a weightf loss and atfends actfvitfe	es
	indicated defir	nitions including, but			as prior tfo tfhis inciden (£ xhibitf #	2).
	not limited to,	"11. Any Villas			Dasidanet Funa intermitanted	
		who has knowledge			Residentf E was intferviewed By tfhe Qualitfy oft Lifte Directfor	
		le cause to believe an			on April 29, 2011, tfo detfermine	
					ift tfhere had been any otfher	
	Elder has been				instfances oft perceived abuse or	
		iged to make an			neglectf by care givers No instfances were identffted This	
	immediate ora	*			residentf has notf experienced	
	Administrative	e Guide, the Director			a signiftcantf weightf loss and	
	of Nursing or 1	the Social Service			atfends actfvitfes as prior tfo tfhis	
	Coordinator, it	f appropriate"			incidentf(Exhibitf #3).	
	,	11 1			All residentf were intferviewed by	
	Unon request	files related to			The Qualitfy oft Lifte Directfotfartf	
					on	
		abuse received by the			April 29, 2011 and completfed on	
		laced on the work			May	
		cility's Villa 2 and			27, 2011. These questfons were relatfed	
	found on 6/2/1	1 at 5:55 p.m.			To all ftorms oft abuse and neglect	tf
	Review of the	files indicated the			No	
	following relat	ted to care of			instfances oft perceived abuse or	
	Residents B, D				neglectf	
	residents B, E	, und E.			were identffted (Exhibitf #4).	
	1 Daview of	the file related to				
		the file related to				
	· ·	dicated in "Brief			Stfaft members Certffted Nurse Ai	d
	_	The Director of			#2, Licensed Practfcal Nurse #3, ar	nd
	Nursing was a	pproached on			Licensed Practfcal Nurse #5, were	
	4/27/2011 at 1	:00 p.m. by [name],			respectfully tferminatfed on 5/2/11 5/21/11. 5/31/11. The Board oft	,
		ing Aide [CNA #4],			Nursing was notffted by tfelephon	e
		G [

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155770 06/03/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN47122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE stating she wanted to meet with May 2, 2011 and May 31, 2011 her....There was an allegation made relatfed tfo ftndings by Directfor oft of physical abuse related to Nursing and Human Resources. transferring an Elder...." Atforney General which was notffted June 17, 2011 (Exhibitf #5). A handwritten statement, signed by CNA #4 on 4/29/11, indicated, "On The Administfratfor and tfhe Directfor oft Nursing reviewed tfhe Abuse and 4/25/11, [name of CNA #2] were Neglectf Policy and Procedures on getting [name of Resident E] up and April 29, 2011 (Exhibitf #6). dressed for the day. When The Directfor oft Nursing inserviced changing her nightshirt [name of tfhe stfaft on tfhe Abuse and Neglectf CNA #2] was very rough and Policy and Procedure including tfhe requirementfs tfo reportf any pulling on her arms. When rolling suspectfed her over she did not wait for abuse or neglectf immediatfely assistance from me or give Elder on April 28, 2011 and completfed on April 30, 2011. This in-service was any warning what she was doing. I ftollowed witfh a writfen postf tfestf tfo had pulled the bed away from the ensure competfence in tfhe wall to be able to assist on the knowledge oft abuse and neglectf (Exhibitf #7) opposite side and caught [name of Resident E] before her head hit the The Directfor oft Nursing will in-service railing. The rest of the day when stfaft quartferly ftor one yeathen [name of CNA #2] would approach annually tfhereafter ongoing [name of Resident E] would close (Exhibitf #8). her eyes and pretend to be asleep. The Policy oft educating all new [Name of CNA #2] did try to feed employees prior tfo working atf tfhe [name of Resident E] at breakfast Villas will contfnue. Eftectfve 6/20/11, but was loud and acting in a very all applicantfs during thhe intferview forceful manner and [name of process will be given a behavior Resident E] would not open her tfestf tfo ascertfain any potfentfal oft

STATEMENT OF DEFICIENCIES (X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	00	COMPLETED	
		155770	B. WIN			06/03/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1002 SI	STER BARBARA WAY		
VILLAS OF GUERIN WOODS				GEORG	GETOWN, IN47122		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	TE COMPLETION		
TAG	,		+	TAG	DATE		
	eyes or mouth"				abusive or harsh behavior and will be dismissed ftrom tfhe intfer	view	
					process accordingly (Exhibitf #9).	view	
		the file related to					
	Resident D, in	dicated in "Brief					
	Description: 7	The Director of			Any tfemporary stfaft being utflize	d	
	Nursing was a	pproached on			has been and will be in-serviced o		
	4/27/2011 at 1	:00 p.m. by [name],			tfhe		
	Certified Nurs	ing Aide [CNA #4],			SPECIFIC ftacilitfy Abuse and Neglo		
		nted to meet with			Policy and Procedure oft tfhe Villa (Exhibitf #10).	S	
	_	as an allegation made			(EXHIBITI #10).		
		•			The Qualitfy oft Lifte Directforserv	rice	
	of mental abus				tfhe Residentf Council on abuse ar		
	comment mad	e about odor during			neglectf on May27, 2011, and Mar		
	elimination."				21, 2011. The Elders were instfruction	σπεα	
					tfell stfaft tfhey fteltf comftortfable	e	
	A handwritten	statement, signed on			speaking tfo		
	4/29/11, indica	nted, "On 4/25/11			ift tfhere were concerns and tr		
	l '	dent D] had an			tfo speak tfo tfhe Directfor oft Nur or	rsing	
	=	of bowel issue. She			Administfratfo(Exhibitf #11).		
					,		
	• •	t with herself that she					
		lp in cleaning up. I			The Qualitfy oft Lifte Directfor will		
		that it was no big			Auditf,tfhrough intferview15% OF The elders randomly tfo identffty a	any	
	deal. [Name of	of CNA #6] and I			Perceived instfances oft abuses an	•	
	cleaned her up	(shower) and got her			neglectf weekly fto# weeks, biwee		
		iving room after			ftor tfwo montfh s fhen as		
	assuring her that no one but us				recommended		
	_	s going on. [Name of			by tfhe Qualitfy Assurance Commitfee.		
		walked in and said,			These auditfs will be presentfed tf	o tfhe	
	_				Administfratfor on an ongoing bas	is	
		t is that smell?' all			(Exhibitf #12).		
	right beside [n	ame of Resident D].					

011509

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155770	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMP 06/03/2	LETED	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN47122					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE RIATE	(X5) COMPLETION DATE	
	whispered that D] had a bowed not gotten every yet I went to be the bathroom [name of LPN [name of Resistand, 'No won been cleaned #3] then went Resident D's] spraying air for continued spraying air for continued spraying air for continued spraying air for continued spraying and was afraid what had happed During intervence 2:05 p.m., the Administrator was no longer facility. The Administrator know why CN	aying outside of the around [name of who was sitting in one coom chairs. [Name of was crying at this point of that everyone knew bened" The with on 6/2/11 at Assistant of indicated CNA #4 on staff at the			The Administfratfor will bring to auditfs the Qualitfy Assura Commitfee ftor any recommendations ftor fturtifher action Straft ftles were auditfed at00% June 17, 2011 ftor license back Check by Jennifter Nally HR. Al Was ftound the have acceptfab License background check in place (Exhibitf #13).	6 on ground I stfaft e		

		IDENTIFICATION NUMBER		ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155770	A. BUI B. WIN	LDING		06/03/20	
NAME OF F	AD CLUDED OD CLUDDI IED		D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER			1002 SI	STER BARBARA WAY		
VILLAS OF GUERIN WOODS				GEORG	GETOWN, IN47122		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	abuse. The As	ssistant Administrator					
	indicated the fa	acility had been					
	inservicing fre	quently about abuse					
	prior the repor	t, so staff had					
	become more	aware.					
	3. Review of t	the file related to					
	Resident B ind	licated in "Brief					
	Description: A	At the monthly staff					
	meeting Director of Nursing [DON]						
	was talking to	the staff about abuse					
	and different ty	ypes of abuse. The					
	staff was being	g instructed on the					
	importance of	reporting any abuse					
	to the Adminis	strator and Director of					
	Nursing. The	DON was					
	1 1 1	[name], Certified					
	Nurse Aide [C	NA #6], stating that					
	she had an abu	ise allegation against					
	a nurse. [Nam	ne of CNA #6] stated					
		was [name of LPN					
	#5], Licensed	Practical Nurse, who					
	was being verb	cally abusive to this					
		ted that [name of					
	=	d tell elder to 'shut					
	_	f and quit acting like					
	_	document indicated					
		rpetrator, LPN #5,					
	was suspended	1 5/25/11, pending					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155770	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED
NAME OF PROVIDER OR SUPPLIER VILLAS OF GUERIN WOODS			 1002 SI	DDRESS, CITY, STATE, ZIP CODE STER BARBARA WAY SETOWN, IN47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	investigation, 5/31/11.	and terminated on				
	and dated 5/26 indicated relat Resident B, "[went in to [nat [room number her to shut up, acting like a b leave and I we statement did of the verbal at A handwritten and dated 5/22 indicated, "I hof LPN #5] be with [name of times. As in second Resident B] ye yelling it's unlast time we we I have heard hopinion about office while in	statement, signed 7/11, by CNA #10 ave witnessed [name sing verbally rough Resident B] a few aying '[Name of ou need to stop your needed and ridiculous' worked together. Also er voicing her the elders from the in the kitchen."				
	During intervi	ew on 6/3/11 at 12:15				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4RJO11 Facility ID: 011509

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155770		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 06/03/2	LETED				
NAME OF PROVIDER OR SUPPLIER VILLAS OF GUERIN WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN47122						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE			
	of abuse, CNA had a class about reporting indicated one employee at the	on what abuse is, and g immediately. She CNA, who was a new are facility, told her at ity they "didn't are like here."							